THE WELFARE OF CHILDREN IN HOSPITAL

A memorandum, here abbreviated, based on evidence submitted by a subcommittee of the British Paediatric Association in February, 1958, to a subcommittee of the Central Health Services Council under the chairmanship of Sir Harry Platt.*

Changing Pattern

In recent years the pattern of disease in children has changed and with this there has been a considerable change in the work and the outlook of paediatricians, a change which is perhaps not universally appreciated by other doctors who received their paediatric training in what is almost a different era.

Until recently death in childhood was mainly attributable to pneumonia, tuberculosis, and other infectious diseases. To-day deaths among babies in the first month of life are as numerous as deaths in the whole of later childhood. As a result the paediatrician has become more intimately involved in the problems of the newborn baby, and in collaboration with obstetricians and other colleagues in the maternity services is obtaining a better understanding of the causes operating before, during, and after birth of conditions leading to death in *early infancy*.

In attempting to reduce mortality in *later childhood* the paediatrician's interests are turning more and more to the prevention or cure of leukaemia and other "cancers," congenital malformations, and accidents, as well as to a better understanding of a large number of rare but recently recognized diseases. Although infectious diseases are less frequently fatal, they are by no means conquered.

To an increasing extent the paediatrician's life is concerned not with potentially fatal disease but with disorders which, while seldom fatal, do cause serious disablement and unhappiness in childhood. Many chronic or recurrent bodily disorders of childhood as well as what was called "nervous debility" were not long ago considered to have a purely physical basis and were treated symptomatically. To-day there is a growing understanding that these bodily disorders may have their origin in emotional as well as physical disturbances and the prospects of prevention as well as cure have improved. In addition to children with bodily disorders, the origins of which are found to be in emotional and social difficulties, the paediatrician has referred to him by his colleagues many children with more strictly psychological problems.

The paediatrician's interests have also been redirected in another important aspect—that of preventive medicine. The prevention of most of the nutritional disorders and many of the infections of childhood is both understood and applied; the prevention of accidents is actively pursued and has already shown good results. A natural development has been the paediatrician's growing interest in the possibilities of preventing disease in adult life. This is of particular importance in relation to the prevention of mental illness and emotional disturbances in later life.

Child in Hospital

Recent advances in the welfare of children in hospital have in part followed from these changes in the interests of the paediatrician. The children's physician is conscious of the fact that his interest in patients is not limited to the times when they are in a hospital ward. He is equally conscious of the lasting importance which a stay in hospital may have on a child's life.

It is recognized that the admission of a young child to hospital, involving separation from home, may be a misfortune quite apart from the misfortune of illness itself. Even where a young child is concerned the misfortune is not often serious, especially if the stay in hospital is short. The older child seldom suffers any lasting ill effects. None the less a thorough understanding of the problems involved by those responsible for the care of children in hospital is essential if the risks of emotional (and sometimes physical) damage are to be minimized.

Avoidance of Admission to Hospital

Admission of a young child to hospital should not be lightly undertaken, and, when possible, alternative arrangements for his treatment or investigation should be made. Empty beds in the children's ward are as much a matter for congratulation as empty beds in a smallpox hospital, although in either case beds must be available to meet the peak demand.

We consider that arrangements for admission through emergency bed services or through casualty departments are far from ideal. Wherever possible the question of admission should be discussed by direct consultation between the family doctor and hospital doctor, if possible the consultant.

Where a consultant paediatrician's responsibilities cover a large area he will seldom be readily available by telephone. Greater ease of consultation with the family doctor is one of the many advantages which would follow the appointment of a second consultant paediatrician to regions at present served only by one (Gairdner, 1956).

The statutory home nursing service is not always used to the fullest extent. The development of this service in Rotherham and elsewhere and the St. Mary's Hospital (Paddington) Home Care Scheme for sick children are worthy of study. The co-operation of surgeons should also be sought. The period of admission to hospital for certain operations (such as repair of hernia in babies) can sometimes be reduced by careful organization. Admission for the day only or at the most a few days is already arranged in a number of hospitals.

Hospital Accommodation

Children's blocks in large general hospitals should be as self-contained as possible. All children's beds should be gathered in a single ward unit or series of units with a consultant paediatrician in charge of the department and its general ward arrangements although the clinical responsibility for individual cases may be that of other physicians and surgeons. Medical and surgical cases can be advantageously combined in one ward and there should seldom be any need to transfer a child from one ward to another. Neither children nor adolescents should be admitted to adult wards.

Accommodation should be made available wherever possible for the mothers of infants and toddlers, preferably with the mother sleeping in the same room as her child (such accommodation should not be restricted to nursing mothers). In many hospitals, where provision of this kind is not possible, night accommodation could be found for mothers who are prepared to care for their children by day. Accommodation allocated to mothers in hospitals should include a communal sitting-room. Many mothers who are employed or who have other children are unable to leave home to care for an infant in hospital, but this is not a justifiable argument against providing the service for those who can take advantage of it.

The problem of adolescents in hospital is a subject which requires special study. In the planning of new hospitals their needs should be considered with a view to providing separate wards if the number of adolescents requiring admission warrants it.

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Unless the parents or general practitioner object a child should, whenever possible, be *readmitted* to the same hospital and to the same ward. Not only will previous records, *x*-rays, etc., be immediately available, but, more important, the child will be known to the staff and the staff and hospital to the child. Emergency bed services should be instructed to inquire about previous admissions when requested to arrange for a child to be taken into hospital.

There is a need for a special study of the necessity for the existence of long-stay hospitals and convalescent homes in the arrangements for health services for children. In future, accommodation for infectious fevers should be made available within a general hospital or children's hospital. Paediatricians should gradually assume responsibility for children's beds in existing fever hospitals.

There must be adequate space for recreation and for eating meals out of bed. Facilities for open-air treatment and recreation are essential and should wherever possible be in close proximity to the ward. Gardens are preferable to balconies.

It is of the greatest importance that separate offices should be provided for the ward sister and house officer in order that parents can be interviewed in privacy and records written without unnecessary disturbance.

A treatment room for minor surgical procedures, etc., is a necessary adjunct to a children's ward.

The provision of facilities for visitors (see below) and the provision of space for prams must also be taken into consideration.

Admission to Hospital

The doctor concerned must accept responsibility for appropriate explanation to the mother and her child of the need for admission to hospital and of the proposed investigation and treatment, but additional explanation by the almoner can often be helpful. The provision of leaflets explaining life in the hospital is also to be recommended. The co-operation of surgeons should be sought in making similar arrangements for the admission of their patients.

We believe that the fathers of children should be consulted as often as possible before admission to hospital is arranged. They are the legal guardians of their children and nothing should be allowed to detract from their authority.

Whenever possible the child should see the ward and meet the sister in charge prior to planned admission. An opportunity should be found for ensuring that the mother is able to explain to her child the reasons for his admission to hospital and to tell him truthfully that she is going to leave him there. It is a common experience to find that parents lie to their children on these occasions to avoid a painful scene. These are matters which can be dealt with in a leaflet.

Consideration should be paid to the wording—too often abrupt and impersonal—of the notice cards sent to parents requesting admission of children on waiting-lists.

Avoiding Delays

Children's wards should have their own admitting system. Delays should be avoided and the child should be welcomed on the ward by a senior member of the nursing staff within a few minutes of his arrival at the hospital. Administrative arrangements should be reviewed to make it possible for the mother to visit the reception or records department for necessary documentation after she has left her child in the ward. It is of obvious importance how the child is parted from his parents. Admission procedures within the ward should be unhurried; the mother and child should have plenty of time together to discover the lay-out of the ward. The mother should assist in putting the child to bed.

The ward sister or her deputy should inquire about the child's habits, his dietary likes and dislikes, the expressions he uses for emptying his bladder and bowel and so on. She must then explain to the child the ward routine so far as it concerns him, visiting arrangements, toilet facilities, etc. Wherever possible the child should retain some of his own possessions and clothing in hospital.

Children's likes and dislikes vary enormously. It is not the duty of the hospital staff to modify a child's dietetic habits during a short stay in hospital unless these are directly related to his illness. The dietary needs of children should be considered separately from those of adults in general hospitals. It should be a special responsibility of someone on the catering staff to ensure that the children are provided with the food ordered by the ward sister.

Education

Not all hospital authorities are aware of the obligations imposed by the 1944 Education Act on local education authorities to make provision for the teaching of short-term cases in hospital. The local education authority can also be requested to provide nursery instruction for children under school age. The emotional strain of admission to hospital even for short periods may in the case of older children be increased if they feel that they are missing school work.

The importance of scholastic examinations and the time needed to study for them is far too easily brushed aside by keeping children in bed or in hospital, especially at the age of 10 or 11 years. The parents should be encouraged to consult with their child's own class teacher, so that he can arrange suitable work for the child and if possible visit him personally. Examinations can sometimes be taken in hospital. But we strongly advocate regular daily attendance by a special teacher which is in many respects more satisfactory than *ad hoc* arrangements for individual children.

In large children's hospitals or departments the educational needs of children under 5 years should ideally be in the care of a trained nursery school teacher.

Recreation and Religion

There is no justification for neglect of recreational facilities even in children's wards for acute diseases. Toys suitable for each age group should be provided, with the necessary cupboard space (hospitals abound in 200-piece jigsaws, but rarely offer a 20-piece wooden jigsaw for little children). Children's libraries should be brought up to date, and kept up to date in terms of quality, variety, and age range. It should be possible to find voluntary helpers to assist in providing suitable recreation for the child.

The visiting by voluntary workers is particularly important in long-stay country hospitals in which visiting by parents may be infrequent. It is essential that the work of these volunteers should be under the general supervision of and with the approval of the sister. Occupational therapists give great assistance in particular cases, especially in long-stay hospitals.

Ideally the ward sister should conduct evening prayers if she can do so with enthusiasm and conviction. This is especially important for children coming from homes with religious background. The Agreed Syllabuses worked out under the Education Act point the way to the common ground enjoyed between denominations. Consideration should be given to the appointment to children's wards of chaplains who have an interest in or aptitude for children.

Painful Procedures

Certain investigations and treatment may occasionally be painful or alarming; consultants and ward sisters should review from time to time the necessity for such procedures. For example, the administration of oral penicillin has largely replaced the painful injections previously necessary.

The advice of the anaesthetist should be sought in considering the use of local or general anaesthesia for necessarily painful procedures. The doctor who is to carry out any treatment, anaesthetic, or investigation should always give an explanation to the child, truthful, but suitable to his years.

The structure of the ward and ward furniture must be such as to minimize the risk of physical danger. However, management committees must be encouraged to appreciate that, in the children's best interests, those caring for them in hospital must be prepared to take some risks just as their parents do at home. Moreover, the ward sister must not be made to feel that she is personally responsible for all accidents. This leads to an atmosphere of fear and disapproval and to a lack of free and open discussion on the causes of accidents.

Visiting

Parents should be encouraged to visit children of all ages as much as possible. Daily visiting should not be considered obligatory, but its importance especially for those under 5 years of age should be emphasized. In most children's hospitals daily visiting is now permitted, but when this is restricted to certain hours the ward sister must be ready to make exceptions in the case of individual parents and children. Moreover, there should be no set limit to the length of visit; one hour may well be not long enough, especially for the younger child. However, there is much to be commended in unrestricted visiting, and where this has been tried it has not been found to impose a serious strain on the nursing staff. We wish to emphasize that facilities for anything less than daily visiting are to be condemned.

There are occasional children in a ward who, no matter what arrangements are in force, are not visited by parents for one reason or another. These children require special but not too obtrusive consideration—for example, visits from members of the W.V.S. or N.C.S.S.

Consultants should be ready to permit parents to take their children out for the day or home for the week-end where it does not interfere with treatment or investigation, despite the effect on the bed occupancy rate.

Visiting should be permitted in fever hospitals.

Liaison

The importance of keeping in touch with parents, general practitioners, local health authorities, and other paediatricians concerned with the welfare of the child cannot be overestimated. It should be considered the privilege of the consultant paediatrician or surgeon to report progress personally to parents when they visit the ward and not to delegate this duty to the house officer, although in most cases the house officer, sister, and almoner should be present. The value of these arrangements has been proved in practice.

A ward sister's duties necessitate much clerical work, and the provision of some secretarial help would be extremely valuable. This would be more easily arranged if shorthand-typists were attached to individual departments of a hospital rather than belonging to a central secretarial pool. As an alternative to secretarial assistance we suggest that there is much to be gained in the employment of sisters' aids. These members of the staff are girls of 17 years of age who have been accepted as student nurses by hospitals and who will begin preliminary training at the age of 18 years.

A parent should always accompany a child to another hospital, but if this is impossible the ward sister should assure the child that his parents will not lose him. Small cars carrying out one duty at a time should be employed. It is sometimes forgotten that children having to wait during day visits to strange hospitals need feeding.

Surgical and Psychiatric In-patients

All that we have said regarding the care of children in hospital applies with equal emphasis to those admitted for surgical treatment or investigation. The welfare of these children is sometimes in danger of being overlooked; the staffs of surgical wards do not always share the recent change of attitude to children in hospital. The avoidance of unnecessary admission for operation has already been mentioned. Special consideration should be given to the frightening circumstances attending admission in accident cases, for acute major surgery, or for ear, nose, and throat operations. Whenever possible suitable explanation should be given to these children; for instance, they can be assured that bleeding is not dangerous. The importance of effective premedication should not be forgotten when urgent or unplanned surgical procedures are necessary. The parents should when possible be present when a child recovers from general anaesthesia.

The lack of sufficient suitable in-patient accommodation for emotionally disturbed and mentally ill children is a serious gap in the present health service. In centres large enough to justify it there is a need for psychiatric observation wards in close association with paediatric units. These wards should be under the supervision of child psychiatrists and staffed by nurses with a knowledge of child health and trained in mental health.

Discharge from Hospital

Before a child leaves hospital an explanation should be given by the doctor in charge and preferably to both parents on what happened to the child while in hospital and about his present condition. Where behaviour problems at home are expected these should also be explained.

A full report containing recommendations for future treatment should be sent to the family doctor as soon as possible (supplemented when necessary by a telephone call). Appropriate information should with the consent of the parents also be provided for the local health authority and education authority to avoid the all-too-common occurrence of conflicting advice to the parents.

Out-patient and Casualty Departments

In order to minimize the time that parents and children are kept waiting an efficient appointments system must be maintained.

In all large out-patient departments visited by children there should be a receptionist to whom parents are directed immediately on arrival. She is able to help those who do not know what to do, nor whom to ask, and to whom the nursing staff are often too busy to attend.

The children's out-patient department should contain the following: (1) A waiting-room of adequate size, warmth, and general comfort with a play space and provision of toys, magazines, etc. (2) A cafeteria. (3) Suitable toilet accommodation. (4) A telephone for the use of parents. (5) A separate and warm undressing and weighing room for the babies and toddlers, who are too often exposed to infectious disease from older children (whooping-cough is a particular menace). (6) Undressing cubicles for older children with facilities for weighing and urine collection. When required, a cubicle may be set aside for a mother to breast-feed her infant. (7) A separate consulting-room for each doctor, in order that parents may be interviewed in privacy.

Ideally in a general hospital the sister in charge of the children's ward should also be responsible for the out-patient department, and the nursing staff should also be interchangeable.

The sight of bewildered parents and tired children trying to find their way to *x*-ray and pathology departments, etc., in large hospitals is all too common. Escorts should be provided, and their duty would be suitable for sisters' aids. The almoner should be available at the times of children's out-patient clinics for consultation with the paediatrician and for interviews with the parents.

To-day the special needs of children in casualty departments are often ignored. In fact, a child is often exposed to unpleasant experiences due to the presence of aged patients, the unconscious and the bleeding, or to frightening experiences resulting from often necessarily hurried treatment and the fears of the unknown.

The paediatrician in a general hospital should have a share in the administrative arrangements for the casualty department. We also recommend that in large hospitals a senior surgeon should be responsible for the running of the

(*Continued at foot of next page*)

To-day's Drugs

With the help of expert contributors we publish below notes on a selection of drugs in current use.

Ultandren (Ciba).—Fluoxymesterone is the 9α-fluoro-11β-17β-hydroxy derivative of methyltestosterone, supplied in tablets of 1 and 5 mg. It appears to have precisely the same anabolic and androgenic actions as testosterone and is effective orally. Its potency is considered to be five times or more that of methyltestosterone by mouth—and therefore about the same as that of testosterone propionate by intramuscular injection.

The principal indications are male hypogonadism, whether congenital or acquired, and, in the female, the palliation of inoperable breast cancer. For the remaining conditions for which androgens are sometimes used—menstrual disorders, osteoporosis, delayed healing of fractures, and debilitated states in which stimulation of protein anabolism is desired—fluoxymesterone is not the agent of choice because of its high virilizing potency. For these conditions the relatively non-virilizing androgens (such as methylandrostanolone and 17α-ethyl-19-nortestosterone) are preferable. The average daily dose is 1–10 mg., but for carcinoma of the breast up to 20 mg. or more daily may be required. With long-continued treatment at high dosage hypercalcaemia and retention of salt and fluid may occur. The former is an indication for discontinuation of the drug, the latter for reduced salt-intake and diuretics.

N.H.S. basic price: 100 tabs. 1 mg., 14s.; 100 tabs. 5 mg., 62s. 8d.

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department. The post of casualty officer is an extremely exacting one, and yet it is often filled by an inexperienced newly registered doctor.

Separate waiting and recovery rooms should be provided for children. An anaesthetist should be readily available when treatment is likely to be painful.

The almoner attached to a children's department has a very special contribution to make to the welfare of patients attending out-patient sessions and admitted to the wards. Her contribution to the work of a paediatric team consists in the understanding appraisal of economic, family, domestic, and social considerations with a bearing on medical aspects. The services of an almoner are particularly valuable in dealing with children referred on account of emotional and behaviour problems. At present some hospitals are still without any establishment for almoners, whose valuable service is thus denied to children. Establishments should be provided in such hospitals.

Hospital Subcommittees on the Welfare of Children

Where children are treated in general hospitals their interests may be relatively neglected in comparison with the interests of the more numerous adult patients. We recommend that the board of governors or hospital management committee of a general hospital should set up standing subcommittees of lay, paediatric, surgical, and nursing members to consider the total well-being of children in their hospital.

Many of the recommendations made in our report are for refinements of practice desirable in hospitals where the standards of care of children are already high. Many paediatricians, however, work in hospitals where the facilities for the welfare of children are deplorably low. We urge that special consideration should be given to these less favourable hospitals.

REFERENCE

Gairdner, D. (1956). *Proc. roy. Soc. Med.*, **49**, 974.

Correspondence

Hospital Sterilization

SIR,—We have read your special correspondent's account of the recent conference at Southampton on "Hospital Sterilization," together with your leading article on the same subject (*Journal*, December 27, pp. 1589 and 1582). We think it will be of interest to your readers to know that in this unit during the last six months a system of central sterile supply, using double-thickness linen packs, has been in operation for surgical instruments and dressings used both in the operating theatre and in the wards. This has led to the complete elimination of the use of "boilers," antiseptic solutions, and drums, both in wards and in operating theatre, since all sterile material is now autoclaved.

An unselected proportion—10% of the packs—has been sampled bacteriologically (*a*) immediately after removal from the autoclave and (*b*) after three weeks' storage in a dry cupboard, no cardboard boxes or special containers being used. The result of the experiments so far have completely justified the change in method, and in particular have shown that it is safe to store such sterile material for a period of up to three weeks without any special precautions.

Apart from questions of sterility, the method has shown certain other advantages in a hospital such as this where due reliance must be placed on part-time and partly trained staff. The assembling of packs, the dressings in which have been made of standardized sizes, can be accomplished during normal working hours by unskilled labour. The provision of a sufficient supply of sterile packs containing both instruments and dressings has meant that there is no delay in preparing for a dressing at any time of the day or night in the wards. Similarly, the laying-up time in the operating theatre is greatly reduced. It has been our practice in carrying out ward dressings to dispose of contaminated dressings into an ordinary grocer's paper bag, which is closed and removed from the ward before proceeding with the next dressing.

From the administrative point of view, savings have been effected by the elimination of drums, the elimination of the costs of operating boilers in the wards and theatre, a reduction in wastage of dressings, and an increased life for rubber gloves, as they do not need sterilizing so long when they are not in a drum. An additional cost, however, has been the provision of extra instruments so that a sufficient number of sterile instrument packs may be always available. Over all, however, a very considerable economy is effected both financially and in staff time.

No difficulty has been experienced in training the nursing staff in the new technique.—We are, etc.,

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Epistaxis in Hypertension

SIR,—Dr. J. R. A. Mitchell (*Journal*, January 3, p. 25) gives an account of the incidence of nose-bleeding in patients suffering from high blood pressure. From the documents of 374 patients who attended the Radcliffe Infirmary and were found to have hypertension he found